Must be received by the Benefits Department within 31 days of the qualifying event. MS 1022.

Press Tab to begin filling out the form.

SF 4400-MED # (6-99) Supersedes (2-98) issue

TOP ENROLLMENT/CHANGE FORM

United of Omaha
A Mutual of Omaha Company

EMPLOYER'S NAME SANDIA NATIONAL LABORATORIES GROUP # EN-20K8 (NM)
EN-20K9 (CA)
GUSI-20LI (PPO/Out-of-Area)

A. EMPLOYEE INFORMATION:

☐ Employee ☐ Retiree ☐ COBRA ☐ Surviving Spouse (Check one)
☐ New Enrollment ☐ Change ☐ Reinstatement (Check one)

Are you married to a Sandia employee? _____ If Yes, Name and SSN# of spouse _____

LAST NAME | FIRST NAME | MI | Date of Birth | Social Security#

ADDRESS | CITY | STATE | ZIP

HOME PHONE | BUSINESS PHONE

☐ SINGLE ☐ MARRIED

UNION AFFILIATION: ☐ **NONE** ☐ **MTC** ☐ **OPEIU** ☐ **SPA**

B. MEDICAL:

Enrollment for: (Please check one) ☐ Employees Only ☐ Employee and Spouse ☐ Employee & Children ☐ Employees Spouse & Children ☐ New Dependent

Employee and Dependent Information: Please list below each family member you wish to be covered. If more than five children, obtain an additional Enrollment/Change Form and attach to this form.

Physician Selection: Select a Primary Care Physician for each person listed. (Not applicable for PPO/Out-of-Area Plan participants)

Last Name, First Name	Soc. Sec. #	Sex	Birth Date	Primary Care Physician Name	Primary Care Physician I.D. Code
Employee					
Spouse					
Oldest Child					
Child					
Child					
Child					
Child					

NOTE: If enrolling an incapacitated dependent, call the Benefits Customer Service (845-2363) for assistance.

C. DEPENDENT INFORMATION: - Do you or your dependents have other group health coverage

☐ YES ☐ NO IF YES, PLEASE COMPLETE

SPOUSE'S NAME (IF NOT SHOWN ABOVE) SOC. SEC. #(IF NOT SHOWN ABOVE)

IS SPOUSE ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO CARRIER/HMO NAME: _____

POLICY # _____ EMPLOYED BY: _____

D. QUALIFYING EVENT:

DATE OF EVENT _____

Reason for Enrollment/or Change: ☐ Marriage ☐ Divorce ☐ Birth ☐ Adoption ☐ Leave ☐ Other

E. EMPLOYEE'S SIGNATURE:

I elect coverage as indicated above, and hereby authorize all hospitals, physicians, medical service providers, pharmacists, employers, and all other agencies or organizations (including all insurers and pre-paid health plans) to permit United of Omaha Life Insurance Company, or their representatives to see, or to get a copy of all medical, prescribed drugs, employment and insurance coverage records which pertain to me or any member of my family. This information will be used in connection with claims for benefits and utilization review and will be kept strictly confidential. This authorization shall remain valid for the term of this coverage. I understand that if a covered individual is injured through the act or omission of another, United of Omaha Life Insurance Company requires reimbursement for the benefits provided in an amount not to exceed any damages collected (where permitted by law).

Signature _____ Date _____

TO BE COMPLETED BY EMPLOYER

Covered Effective Date _____ SNL _____

Sandia Hire Date _____ Rx _____

Pru _____

1st Copy: UNITED OF OMAHA LIFE INSURANCE COPY

2nd Copy: EMPLOYER COPY

3rd Copy: EMPLOYEE COPY(Retain as Temporary Identification Card)